

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined Edward Thompson in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when:

- ☐ wearing corrective lenses ☐ driving within an exempt intracity zone (49 CFR 391.62)
☐ wearing hearing aid ☐ accompanied by a Skill Performance Evaluation Certificate (SPE)
☐ accompanied by a _____ waiver/exemption ☐ qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER <u>Barbara Elliott</u>		TELEPHONE (812) 263-2013	DATE 04/26/05
MEDICAL EXAMINER'S NAME (PRINT) <u>Barbara Elliott</u>		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician Assistant <input checked="" type="checkbox"/> Advanced Practice Nurse	
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO. / ISSUING STATE <u>71000103</u> <u>INDIANA</u>			
SIGNATURE OF DRIVER <u>Edward Neil Thompson</u>		DRIVER'S LICENSE NO. <u>4657210</u>	STATE <u>AL</u>
ADDRESS OF DRIVER <u>801 5th Ave Geneva AL 36340</u>			
MEDICAL CERTIFICATE EXPIRATION DATE <u>04/26/05</u>			

DISTRIBUTION: 1 COPY TO THE DRIVER, 1 COPY TO THE MOTOR CARRIER

649-F (Rev. 10/03) (6045)

Medical Examination Report FOR COMMERCIAL DRIVER FITNESS DETERMINATION

Driver completes this section.

1. DRIVER'S INFORMATION		Social Security No.		Birthdate	Age	Sex	New Certification	Date of Exam
Driver's Name (Last, First, Middle) <i>Thompson Edward West</i>		417-88-9319		10-30-42	41	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<input checked="" type="checkbox"/> Recertification <input type="checkbox"/> Follow Up	4-26-06
Address 801 5th Ave		City, State, Zip Code Geneva, IL 60130		Work Tel: ()		Driver License No.		State of Issue
				Home Tel: (384) 449-1657		4657210		IL

Driver completes this section, but medical examiner is encouraged to discuss with driver.

2. HEALTH HISTORY

Yes	No	Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Any illness or injury in the last 5 years?		Lung disease, emphysema, asthma, chronic bronchitis	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Head/Brain injuries, disorders or illnesses		<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Seizures, epilepsy		<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
medication		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Eye disorders or impaired vision (except corrective lenses)		<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ear disorders, loss of hearing or balance		<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart disease or heart attack; other cardiovascular condition		<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
medication		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart surgery (valve replacement, bypass, angioplasty, pacemaker)		<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High blood pressure		<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Medication		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Muscular disease		<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Shortness of breath		<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature *Edward West Thompson* Date *4-26-06*

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

Type 2 dm. Glucophage + Glucobrol - takes pen - when blood sugar > 165
1/2 doz. St. John's wort on a daily basis. No symptoms. All clear

TESTING (Medical Examiner completes Section 3 through 7)

3. VISION Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. Monocular drivers are not qualified.

Numerical readings must be provided.

ACUITY	(UNCORRECTED)	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/100	20/	Right Eye 85°
Left Eye	20/100	20/	Left Eye 85°
Both Eyes	20/100	20/	

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination _____ Name of Ophthalmologist or Optometrist (print) _____ Tel. No. _____ License No./State of Issue _____ Signature _____

4. HEARING Standard: a) Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB. Check if hearing aid used for tests. Check if hearing aid required to meet standard.

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -10 dB for 1,000 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear 5 Feet	Left Ear 5 Feet
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b) If audiometer is used, record hearing loss in decibels, (acc. to ANSI Z24.5-1951)	Right Ear	Left Ear
	500 Hz 1000 Hz 2000 Hz	500 Hz 1000 Hz 2000 Hz
	Average:	Average:

5. BLOOD PRESSURE/PULSE RATE Numerical readings must be recorded. Medical examiner should take at least two readings to confirm BP.

Blood Pressure	Systolic 136	Diastolic 73
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Driver qualified if $\leq 140/90$.

Pulse Rate: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular	Record Pulse Rate: 64
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Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if $\leq 140/90$. One-time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months.	1 year from date of exam if $\leq 140/90$
$\geq 180/110$	Stage 3	6 months from date of exam if $\leq 140/90$	6 months if $\leq 140/90$

6. LABORATORY AND OTHER TEST FINDINGS Numerical readings must be recorded.

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other Testing (Describe and record)

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR
1.015	1.015	neg	neg	2000

4/28/04 6:44 am 207 Fantasy 66666666

Mar-15-02 11:29A The Campbell Agency

850 234 6087

P.02

REQUEST FOR CHECK OF DRIVING RECORD

I hereby authorize The Campbell Agency to release the following information to Florida Transformer, Inc.
(Prospective Employer)

for purposes of investigation as required by Section 391.23 of the Federal Motor Carrier Safety Regulation.
You are released from any and all liability which may result from furnishing such information.

Edward Neal Thompson
(Signature)

8-13-04
(Date)

1. In accordance with the provisions of Section 604 and Section 607 of the Fair Credit Reporting Act, Public Law No. 91-508, I hereby certify that the information requested below will be used for a "permissible purpose" as defined in the Act and that the information received will be used for no other purpose.

2. I further certify that if the applicant named below is denied employment based on the information received, I will identify the source of the report in accordance with Section 615(a) of the Fair Credit Reporting Act.

Scott Seay
(Signature of Requestor)

08/13/04
(Date)

To: _____

Gentleman:

The following named person has made application with our company for the position of Driver (Class A CDL).
As in accordance with Section 391.23 Federal Department of Transportation Regulations, please furnish the undersigned with the applicant's driving record for the past three years.

Edward Neal Thompson
(Name of Applicant)

8015th Ave Geneva AL 36340
(Address of Applicant)

(Former Address)

Date of Birth 10-30-62

Social Security Number 417-88-9319

Drivers License Number 4657210

State of issuance AL

Requested by:

Florida Transformer, Inc.
(Name of Company)

Scott Seay
(Typed Name)

4509 State Highway 83
(Address)

Human Resources Manager
(Title)

DeFuniak Springs
(City)

FL
(State)

32433
(Zip)

Scott Seay
(Signature)

STATEMENT OF VIOLATIONS

§§391.25, 391.2

This form is to be completed at least once every 12 months.

DRIVER'S NAME

Edward Neal Thompson

I certify that the following is a true and complete list of traffic violations (other than parking violations) for which I have been convicted or forfeited bond or collateral during the past 12 months. (If no violations, put NONE in the offense column.)

DATE OF CONVICTION	OFFENSE	LOCATION	COMMERCIAL MOTOR VEHICLE OR AUTOMOBILE
	<u>None</u>		

If no violations are listed above, I certify that I have not been convicted or forfeited bond or collateral on account of any violation required to be listed during the past 12 months.

Edward Neal Thompson
DRIVER'S SIGNATURE

8/13/04
DATE

NAME OF MOTOR CARRIER

Florida Transformer, Inc.

ADDRESS

P.O. Box 507DeFuniak Springs
CITYFL
STATE32435
ZIP

REVIEWED BY: SIGNATURE

Scott Leary
HR MGR

TITLE

Certificate of Review

To be certified by a motor carrier supervisor.

I have hereby reviewed the driving record of _____

DRIVER'S NAME

in accordance with §391.25 and find that he/she:

_____ Meets minimum requirements for safe driving.

_____ Is disqualified to drive a commercial motor vehicle pursuant to §391.15.

Reason for disqualification: _____

SUPERVISOR'S SIGNATURE

DATE

Distribution of Copy: Driver Qualification File with a copy of Motor Vehicle Driving Record attached.

FTI

Alabama Department of

Public Safety

08/18/2004

DRIVER LICENSE ABSTRACT

Reply May Be Made To:

Driver License Division

P O Box 1471

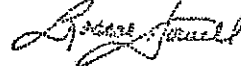
Montgomery, AL 36102-1471

NAME: EDWARD NEAL THOMPSON
 ISSUE DATE: 04/02/2004
 EXPIRATION DATE: 03/26/2008
 RESTRICTIONS:

LICENSE NO: 4657210 STATUS: CURRENT
 LICENSE CLASS: AM CDL STATUS: CURRENT
 BIRTH DATE: 10/30/1962 RACE: W SEX: M
 ENDORSEMENTS:

CONVICTION DATE	OFFENSE DESCRIPTION	OFF DATE	COM VEH	COURT/AGENCY	REP CNSL
05/09/2003	SPEEDING 69/45 MPH ZONE	02/21/2003	P	HOUSTON CO DISTRICT COURT	N
08/29/2002	ACC NO. / 2095274	COMM VEH/N	CNTY/HOUSTON	CITY/DOTHAN	

I hereby certify that this is a true and correct copy of the records in the Driver License Division of the Alabama Department of Public Safety.



ROSCOE HOWELL, MAJOR
 DRIVER LICENSE DIVISION

*** THE INCLUSION OF ACCIDENT DATA IN THIS REPORT ***
 *** IN NO WAY IMPLIES FAULT OR LIABILITY. ***
 *** THIS REPORT CONTAINS INFORMATION REPORTED TO ***
 *** THIS DEPARTMENT FOR THE LAST 3 YEARS. ***

